

PRINTED: 04/20/2017  
FORM APPROVED

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN3315	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  04/17/2017
NAME OF PROVIDER OR SUPPLIER  SODDY-DAISY HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 701 SEQUOYAH ROAD SODDY-DAISY, TN 37379			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies  During the Life Safety portion of the annual Licensure survey conducted on 4/17/17, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 002			

Division of Health Care Facilities  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

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If continuation sheet 1 of 1